Analysis of Suggestions for Medi-Cal Redesign

DRAFT FOR DISCUSSION 4/7-04

	Programmatic Impact	Fiscal Impact on Specialty Mental Health Medi-Cal		
		Federal	**State**	**MHP**
1. Move from traditional therapies such as play therapy to services that have been proven be more effective practices	1. Would require training for staff to gain expertise in providing new types of services. 2. Could produce better outcomes since these practices have demonstrated effectiveness 3. Evidence based practices are not available for all populations or diagnoses. They also change over time as new information becomes available.	Could have a long term reduction in FFP by providing more effective services	Would require significant investment in staff training Could have a long term SGF savings by reducing cost per case by providing more effective services	Would require additional funds for staff training and for retooling existing or implementing new programs
2. Make AB 3632 youth eligible for Medi-Cal	1. This would require a Home and Community Based waiver to expand Medi-Cal eligibility. Youth would have to qualify for an institutional level (defined as a hospital, nursing facility or intermediate care facility for persons with mental retardation) of care in order to be eligible. It could expand the range of services that would be eligible for	Waiver has to be cost neutral—that is, the total amount of FFP can be no more than would exist without the waiver. All health care costs, not just mental health care would have to be included in the waiver and would come under the requirement for cost neutrality The costs for the population being added would previously not have been in the base.	Could increase SGF under EPSDT Could decrease state mandate funding Additional state staffing needed to analyze, develop and implement waiver.	Could increase MHP share of EPSDT growth Could reduce county social service costs for out-of-home care for some of these children/youth.

	reimbursement, as long as the services were necessary to avoid institutionalization			
3. Change EPSDT eligibility to clarify the word "ameliorate"	1. Analysis awaiting more information regarding proposed change.	Analysis pending	Analysis pending	Analysis pending
4. Capitate EPSDT	1. Would create incentives to limit both access and services 2. Would increase program flexibility by eliminating claiming by service, SMAs, settling to cost report, etc. Revenues would be easier to project, and there would be greatly reduced risk of audit disallowances. 3. Would be difficult for small MHPs to continue to exist without some kind of risk pools, risk corridors and/or reinsurance 4. Would require major programmatic and fiscal restructuring. MHPs would need to become more sophisticated in managing access and cost per client	FFP would be dependent on number and type of beneficiaries rather than services provided	SGF expenditures would be dependent on number and type of beneficiaries rather than services provided. Additional state staff needed to develop, implement and monitor capitation.	MHP share of growth would be dependent on number and type of beneficiaries rather than services provided

	since funds would be capped. Both MHP and DMH billing and claiming systems would need to be changed. MHPs would need to report encounter and cost data for waiver purposes, but would not settle to cost under the current cost reporting system.			
5. Establish Medi-Cal eligibility for youth in the juvenile justice system who are awaiting adjudication	1. Would enable programs already providing services to these youth to get FFP to maintain or expand services 2. Could encourage MHPs to develop new services for this population	Would increase FFP This might require a waiver which would carry cost effectiveness requirements Clarifications of existing requirements may expand federal funding	Could increase SGF if new services are implemented for this population	Could increase MHP share of match for EPSDT growth if new services are implemented for this population

6. Provide for/clarify the ability to provide adult peer support services under the Rehab Option and Targeted Case Management or add these services to State Medi-Cal Plan Services might include self-help support groups, drop-in centers, client-run crises/respite services, clubhouses, telephone support lines, etc. for clients at high risk of rehospitalization	1. Support existing recovery-oriented services. 2. Redirect other existing services to recovery-oriented services 3. Expand recovery oriented services	Increase FFP for short term More cost effective services could reduce FFP over the long term	Could require additional state staffing resources to implement	Expanded services would require additional local match More cost effective services could reduce local costs over the long term
7. Add employment services to State Medi-Cal Plan such as vocational assessments, work preparation activities, development of job	1. Support existing employment services 2. Redirect other existing services to employment focused services 3. Expand employment services	Increase FFP for short term More cost effective services could reduce FFP over the long term	Would require additional state staffing resources to implement	Expanded services would require additional local match More cost effective services could reduce local costs

and career development plans, assistance in locating employment and/or integrated supported employment such as outreach/job coaching, on-the-job support, etc.				over the long term
8. Include coverage for services to adults with substance abuse and mental illness; create the ability to provide integrated treatment to those at highest risk for rehospitalization.	1. Allow dually diagnosed individuals to receive integrated treatment for both disorders 2. Encourage expansion of dually diagnosed services/programs	Increase FFP for short term More cost effective services could reduce FFP over long term	Would require additional state staffing resources to implement	Expanded services would require additional local match. More cost effective services could reduce local costs esp for repeat hospitalization over long term
9. Replace day treatment intensive and day rehabilitation for adults with partial hospitalization.	1. Focus adult day services on short-term intensive services using a more standardized partial hospitalization model. Simplify administrative work involved with monitoring and claiming	Assumption is limited impact on FFP, because resources/services would be redirected to other more effective service delivery models.	Would require additional state staffing resources to implement	Same as for FFP

	FFP. 2. Would involve program changes in some MHPs in order to continue claiming FFP			
10. Waive IMD exclusion for freestanding psychiatric hospitals and psychiatric health facilities greater than 16 beds serving adults for inpatient services.	1. Could increase number of acute inpatient beds for some MHPs 2. Could result in hospitals closer to home for some MHPs 3. This could create incentives (by virtue of availability) for more hospitalizations and for larger acute institutions that would ultimately lead away from the concepts embodied in the Olmstead decision and the desired emphasis on less institutional and more community-based services.	Increased FFP for existing services if hospitalization increased.	No impact	MHP savings due to the fact that FFP would cover half of what is now a total local cost Could result in lower rates due to increased competition
11. Align MH Medi-Cal with the private sector for	4. Would reduce ability to provide some psych rehab and case management	Would reduce FFP		Could increase MHP costs for non Medi-Cal eligible

proposed "Tier 2" and "Tier 3" Medi-Cal beneficiaries (those in optional aid codes—does not include those on SSI or TANF)	services for Tier 2 beneficiaries (i.e., residential treatment and day treatment). In some cases there could also be limits on the number of days for some service categories such as inpatient			services. Could result in increased cost for inpatient services if if community-based services of greater intensity than those provided in the public sector are needed to keep clients stable.
12. Share of cost for pharmacy for adults	1. Would make it more difficult for some clients to get medication	No impact on MH FFP unless clients needed more and higher cost services as a result of not getting medications	No impact on SGF for MH unless clients needed more and higher cost services as a result of not getting medications	No impact on MHP local funds unless clients needed more and higher cost services as a result of not getting medications
13. Eliminate coverage for atypical psychotropic medications	1. Clients could require more intensive and expensive services without newer medications	No impact on FFP for MHPs for medication costs, but could result in higher service costs	No impact	No impact on local costs for MHPs for medication costs, but could result in higher service costs
14. Eliminate UMDAP requirement for Medi-Cal beneficiaries	1. Less paperwork			Lower administrative costs
15. Flexible financing like the cash and	1. Would allow consumers to choose their services	Would cap FFP per user	Would require additional state	Would cap local county match per

carry or voucher concept	and would allow them greater flexibility in managing their care 2. Would cap services an individual could receive during a given time period 3. Could result in less services being available since programs could not plan on a certain amount of revenue to develop service capability		staffing resources to implement	user
16. Review and streamline administrative requirements	1. Less administrative work		Would require additional state staffing resources to implement	Reduce administrative costs
17. Obtain exemption from new managed care regulations	1. Less administrative work 2. Some outreach and client protections could be lost	Reduce FFP revenues for these activities	Reduce DMH costs, reduce SGF expenditures depending on which provisions are waived	Reduce local administrative costs